07/23/2008 00:47 FAX 2024429430 HRA ☑004/020

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6534 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS On April 25 and April 30, 2008, the State Agency received a compliant concerning Client #1's care, and persistent pattern of habilitation problems as detailed below: 1. Family members were not informed about unusual incidents and about the outcome of investigations (substantiated); 2. There has been large turnover of staff; and the new staff have not been adequately trained (substantiated); 3. The group homes appearance is in need of improvement (not substantiated); 4. The client's programs have not been implemented and the client appeared to always watch television (partially substantiated); 5. The facility continued to cut the client's hair after they had been asked not to cut it (partially substantiated); 6. The facility did not informed family members of medical appointments and outcomes (substantiated); 7. Family members have not signed consents for the use of medications or have been informed of the risk and benefit of the client's behavior management plan and medications (not substantiated); 8. Family members have not been informed of the client's finances (substantiated); 9. Family members have concerns about the	W 000	Received 8/7/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Thompson TITLE: Program Director (X6) DATE: 8-4-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 1 client's dental health (substantiated); 10. The client wore other people's clothes, which were too large (not substantiated); and 11. There has been no communication with the facility's management (not substantiated).	W 000		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide receipts for withdrawals from the clients personal funds account for Client #2. The finding includes: Review of Client #1's bank statements from July 2007 through April 2008 was conducted on May 7, 2008. The review revealed several withdrawals that totaled $694.51. Although an interview with the Qualified Mental Retardation Professional (QMRP) at approximately 11:00 AM indicated that the was money withdrawn for either clothing or vacation, there were no receipts or evidence of the expenditures.	W 140	W 140 The facility has restructured its accounting system of client funds to ensure that all client funds and expenditure receipts are accounted for. Additionally, the facility will incorporate the new method of accounting of all clients at facility including client's # 1 and client's #2; to include weekly requests forms which will require the QMRP and Program Director's signature. In addition to this new method, all receipts shall be turned in within five days of request by QMRP to Program director. Monthly audits will be conducted by Program director on facility.	7/1/08
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse,	W 148		

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6834 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 148	Continued From page 2 or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to notify family members of significant incidents for two of the four clients residing in the facility. (Clients #1 and #3) The findings include: 1. Review of the facility's unusual incident reports and investigative reports on May 5, 2008 at approximately 5:10 AM, revealed that the facility failed to notify family members immediately of the following significant incidents: a. On January 29, 2008, Client #1 informed the residential staff that her day program staff hit her on the upper arm. b. On January 12, 2008, Client #1 was allegedly locked in her closet by direct care staff. c. On December 17, 2007, Client #3 informed her residential staff that she was inappropriately touched by another client at her day program. 2. The facility failed to inform family members of medical appointments and the outcomes. Interview with the QMRP on May 6, 2008 indicated that Client #1's medical appointments are current with the exception of the dental. The QMRP further indicated that the family member has not inquired about the client's medical health. There was no evidence that the facility notified Client #1's family of her health status.	W 148	W 148 The QMRP has received in-service training on notification on client's behalf to parents, guardians of any significant incidents, client condition changes, serious illnesses, death abuse or unauthorized absence. Furthermore the incident management team shall conduct monthly reviews at this facility on any incidents with QMRP. a. This allegation was investigated on 2/3/08 and the outcome was unsubstantiated. b. This allegation was investigated on 1/17/08 and the outcome was unsubstantiated. c. This allegation was investigated on 1/9/08 and the outcome was unsubstantiated. The QMRP will also notify family members of medical appointments and the outcomes.	7/23/08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 3 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently. The findings include: 1. Upon entry to the facility on May 6, 2008 at 5:00 PM, there were two new staff on duty. Review of the personnel records May 7, 2008 revealed no personnel records to review. 2. The facility failed to ensure that staff had received effective training on implementing Client #2's Individula Program Plan objective. [See W249]	W 189	W 189 Each staff at this facility was provided in-service training on all clients' IPP goals to include client # 2's IPP goals and implementation. 1. Two new staff was in-serviced on July 23rd 2008. Additionally all new staff shall have a personnel file created by date of hire as per company requirements. 2. The facility retrained staff on effective training of IPP goals and implementation of client #2's IPP goals on July 23rd 2008.	7/23/08
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6834 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 4 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated client's individual program plan, each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the Individual Program Plan (IPP), for one of the four clients in the facility. (Client #1) The findings includes: The facility failed to implement Client #1's recreation program as evidenced below: a. On May 7, 2008, at 10:00 AM Client #1's Individual Support Plan (ISP) dated April 18, 2008 was reviewed. The ISP reflected an exercise goal with an objective that "[the client] will exercise for 15 minutes in the morning, and 15 minutes in the PM by doing activity of her choice that elevates her heart rate with two verbal prompts for three consecutive months by 10/08". Review of the May 2008 data sheet reflected that the program was implemented once during the current month. In an interview with the Qualified Mental Retardation Professional (QMRP) on May 7, 2008, she acknowledged that the program should be documented three times per week. b. On May 7, 2008, at 10:00 AM Client #1's Individual Support Plan (ISP) dated April 18, 2008 was reviewed. The ISP reflected a goal to improve cognitive skills with the objective that "[the client] will print her entire first name legibly with gestural assistance for three consecutive months by 10/08."	W 249	W 249 The Facility's QMRP was re-trained on 7/23/08 on proper implementation of all clients' individual program to include client# 1 IPP plans and active treatment formulated by the interdisciplinary team. a. QMRP was re-trained clients' # 1 IPP exercise goal which includes an objective for client # 1 to exercise for 15 minutes at both AM/PM times by three consecutive months until 10/08. b. QMRP was retrained on client's #1 IPP goal to improve cognitive skills with the objective that client #1 will print her entire first name by for three consecutive months by 10/08. Additionally the QMRP was also in-serviced on job description of QMRP duties by the administration on 7/23/08 to include client programs implementation of goals, BSP documentation by	7/23/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6834 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 5 Review of the May 2008 data sheet reflected that the program was implemented once during the month. on May 7, 2008, the QMRP acknowledged that the program should be documented three times per week.	W 249	direct care staff and all other QMRP duties as assigned, which include consistence of oversight on all programs for all clients.	
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely dental services, for one of the four clients included in the sample. (Client #1) The finding includes: On May 6, 2008 at 7:10 PM, Client #1 was observed with brown stains on her teeth. Review of the dental records revealed that on June 12, 2007 the client had a recall examination. The dental consultant form indicated that scaling, prophylaxis, periodontal evaluation and four fillings were recommended, but could not be completed until payment authorization was received. She returned on January 22, 2008, however the client refused dental services. There was no other attempts to obtain dental service.	W 356	W 356 Client# 1 had an appointment for follow up in May of 2008 on the following procedures, scaling, prophylaxis, periodontal evaluation and four fillings but she refused. QMRP will have psychologist implement a desensitization plan by 8/15/08.	8/15/08
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6834 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 6 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to administered medications with current physician's orders for one of the four clients in the facility. (Client #1) The finding includes: During the medication administration on May 6, 2008 at 7:10 PM, Client #1 was observed receiving Thorazine 100 mg. Interview with the medication nurse indicated that the Thorazine 100 mg had been added to her drug regime on the morning of May 6, 2008 to manage the client's maladaptive behaviors. Review of the medical records however, failed to show evidence of a physician order for Thorazine 100 mg.	W 368	W 368 Upon review by RN for facility and the administration client #1's physician order for Thorazine 100mg was evident in the client's file.	
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to administered medications without error. The finding includes: During the medication administration on May 6, 2008 at 7:10 PM, Client #1 was observed receiving Thorazine 100 mg. Interview with the	W 369		

PRINTED: 07/23/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 369	Continued From page 7 medication nurse indicated that the client received the aforementioned medications to manage her maladaptive behaviors. The nurse indicated that Thorazine was initiated on May 6, 2008 and was ordered to be given in the morning. Review of the medical records failed to show evidence of a physician order for Thorazine 100 mg. The records revealed that Thorazine 400 mg had been order, but was discontinued on February 21, 2008.	W 369	W 369 Upon review by RN for the facility and the administration client #1's physicians' order for Thorazine 100mg BID on 4/24/08; in addition to the discontinuance of Thorazine 400mg on 2/21/08 present in client's record.	

07/23/2008 00:48 FAX 2024429430 HRA 012/020

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS	I 000		

On April 25 and April 30, 2008, the State Agency received a compliant concerning Resident #1's care, and persistent pattern of habilitation problems as detailed below:

1. Family members were not informed about unusual incidents and about the outcome of investigations;

2. There has been large turnover of staff; and the new staff have not been adequately trained;

3. The group homes appearance is in need of improvement;

4. The resident's programs have not been implemented and the client appeared to always watch television;

5. The facility continued to cut the resident's hair after they had been asked not to cut it;

6. The facility did not informed family members of medical appointments and outcomes;

7. Family members have not signed consents for the use of medications or have been informed of the risk and benefit of the resident's behavior management plan and medications;

8. Family members have not been informed of the resident's finances;

9. Family members have concerns about the resident's dental health;

10. The resident wore other people's clothes, which were too large.

Received 8/7/08

ERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6834 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Continued From page 1 11. There has been no communication with the facility's management.	I 000		
I 108	3504.15 HOUSEKEEPING Each GHMRP shall assure that each resident has at least seven (7) changes of clothing appropriate to his or her daily activities. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure that clients had clothing that was the appropriate size for one of the four residents included in the sample. (Resident #1) The finding includes: Observations on May 6, 2008 at 5:40 PM, Resident #1 was wearing a pair of jeans that were large at the waist. The belt was wrapped around her waist one and a half times. Interview with the resident indicated, " I'm loosing weight. " Interview with the QMRP on May 7, 2008 indicated her pants were slightly big due to the weight loss. Review of the medical record, she had lost ten pounds over the past calendar year. On May 6, 2008 at approximately 1:00 PM, the client clothing supply was inspected. Although the inspection revealed that the client had clothes, the clothes were purchase prior to the client's weight loss. The QMRP stated that there were making plans to purchase new clothes for the summer.	I 108	1108 The GHMRP has reviewed its policies on assuring that each resident has at least (7) changes of clothing appropriate for daily activities Additionally Resident #1 has had a wardrobe update to include new clothes for the summer and QMRP will ensure that seasonal review of all client's clothing will be conducted to ensure that each client at least (7) changes of clothing as per company policy.	7/23/08
I 203	3609.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job	I 203		

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 203	Continued From page 2 descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Review of the personnel files on May 6, 2008 failed to provide evidence that 7 of the 16 direct care staff, and Qualified Mental Retardation Professional had current job descriptions.	I 203	1203 The GHMRP has revisited it policies on all employee job descriptions. The administration has re-in serviced all managers at this facility to ensure that each supervisor QMRP, HM etc will review the job description with each new employee as well as annually as per company policy. The personnel files for 7 of the 16 direct care staff and QMRP all have current job descriptions on file.	7/23/08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on May 7, 2008, at which time there was no evidence that ten direct care	I 206	1206 The administration has reviewed its personnel policies and structural changes have been made to ensure that each employee, prior to employment and annually thereafter shall have a current physician's certification of a health inventory of health status. Staff #2, #4, #6, #9, #11, #12, #14, #15, #16, and #18 and QMRP for the facility all have current health certificates on file with HR department.	7/1/08

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 3 staff (Staff #2, #4, #6, #9, #10, #11 #12, #14, #15, #16 and #18), and Qualified Mental Retardation Professional (QMRP) had a current health certificate.	I 206		
I 221	3510.2 STAFF TRAINING Orientation training shall be the responsibility of each GHMRP and shall be documented in each employee ' s personnel folder. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure that all staff received their initial orientation training. The finding includes: Review of the personnel files on May 7, 2007, failed to provide orientation training for five direct care staff (Staff #4, #6, #9,#10 and #15).	I 221	1221 The GHMRP has revisited its staff training policies and structural changes within the organization to ensure that all staff receives initial orientation training.	7/23/08
I 224	3510.5(a) STAFF TRAINING Each training program shall include, but not be limited to, the following: (a) Overview of mental retardation including, but not limited to, definition, causes of mental retardation, associated health implications, and frequently used medications, the history of care of individuals with mental retardation, and daily living skills; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure effective training was provide to each staff.	I 224	1224 The GHMRP has revisited its staff training policies and structural changes within the organization to ensure that all staff receives initial orientation training to include an overview of mental retardation, causes of mental retardation, associated health implications, and frequently used medications, history of care of individuals with mental retardation and daily living skills. Additionally all staff have been trained at this facility on 7/23/08.	7/23/08

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 224	Continued From page 4	I 224		
	The finding includes: Review of the training records on May 7, 2008, revealed that the GHMRP failed to provide training in overview of mental retardation.			
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death); This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provide to each staff. The finding includes: Review of the training records on May 7, 2008 revealed that the GHMRP failed to provide training in Human Development.	I 225	1225 On 7/1/08 the GHMRP has revisited its training policies and structural changes have been made to staff training to incorporate human development training to all staff at each facility by	8/15/08
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on interview and review of training	I 229	1229 The GHMRP has revisited its staff training policies and structural changes within the organization to ensure that all staff at the facility receives initial orientation training on specialty areas to include behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies relevant to client needs on 7/23/08.	7/23/08

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 5 documents, the GHMRP failed to provide evidence to validate staff training as indicated by residents' need. The findings include: Interview and the review of the in service training records on May 7, 2008, the GHMRP failed to provide training on nutrition, sexuality, and behavior management.	I 229		
I 231	3510.5(h) STAFF TRAINING Each training program shall include, but not be limited to, the following: (h) Orientation programs for each new employee which shall include philosophy, organization, programs, practices and goals of the GHMRP as well as a review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia; and... This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence on training on its policies. The finding includes: Review of the personnel files on May 7, 2008, the GHMRP failed to have on file, orientation for five all new direct care staff.	I 231	1231 On 7/1/08 the GHMRP has revisited its training policies and structural changes have been made to staff training to incorporate new employee trainings on philosophy, organization, programs, practices and goals of the GHMRP, review of applicable laws, regulations and agreements important to the operation of the GHMRP for the care and treatment of persons with mental retardation in the District of Columbia on a consistent basis. The personnel files on all new direct care staff at this facility contains completed orientation training on 7/23/08.	7/23/08
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized	I 271		

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 271	Continued From page 6 agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of all staffs personnel records. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel files on May 7, 2008, the GHMRP failed to provide evidence of personnel records for the five direct care staff (Staff #4, #5, #9, #10, and #15).	I 271	1271 The GHMRP has had structural changes to the organization on 7/1/08 to include consistent maintenance of administrative records availability upon request at the Human Resources department to an authorized agency inspection and to provide such information within timeframe of inspection by the inspecting agency.	7/1/08
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to provide evidence of the prompt notification of parents or guardians of significant incidents for two of the four residents in the sample. (Clients #1 and #3) The finding includes:	I 374	1374 The QMRP has received in-service training on notification on client's #1 and #3 and all remaining client's behalf to parents, family members, guardians of any significant incidents, client condition changes, serious illnesses, death abuse or unauthorized absence.	7/23/08

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 374	Continued From page 7 Review of the facility's unusual incident reports and investigative reports on May 6, 2008 at approximately 5:10 AM, revealed evidence that the facility failed to notify family members immediately of the following significant incidents: a. On January 29, 2008, Client #1 informed the residential staff that her day program staff hit her on the upper arm. b. On Janaury 12, 2008, Client #1 was allegely locked in her closet by direct care staff. c. On December 17, 2007, Client #3 informed her residential staff that she was inappropriately touched by another client at her day program.	I 374	a. This allegation was investigated on 2/3/08 and the outcome was unsubstantiated. b. This allegation was investigated on 1/17/08 and the outcome was unsubstantiated. c. This allegation was investigated on 1/9/08 and the outcome was unsubstantiated.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the four residents in thefacility. (Resident #1) The findings include: The facility failed to implement Resident #1's recreation program as evidenced below: a. Review of Resident #1's Individual Support Plan (ISP) dated April 18, 2008, on May 7, 2008, at 10:00 AM revealed a exercise goal to improve	I 422	1422 The QMRP was retrained on ensuring that habilitation, training and assistance were provided to residents including resident #1 in accordance with an individual's habilitation plan on 7/23/08.	7/23/08

PRINTED: 07/23/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0130	A. BUILDING _____ B. WING _____	C 05/07/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 8 her recreational and leisure skills. The objective read "[the resident] will exercise for 15 minutes in the morning, and 15 minutes in the PM by doing activity of her choice that elevates her heart rate with two verbal prompts for three consecutive months by 10/08". Review of the May 2008 data sheet reflected that the program was implemented once during the current month. In an interview with the Qualified Mental Retardation Professional (QMRP) on May 7, 200, she acknowledged that the program should be documented three times per week. b. Review of Resident #1's ISP dated April 18, 2008, on May 7, 2008, at 10:00 AM revealed an cognitive goal to improve her skills. The objective read, "[the resident] will print her entire first name legibly with gestural assistance for three consecutive months by 10/08". Review of the May 2008 data sheet reflected that the program was implemented once during the month. In an interview with the QMRP on May 7, 200, she acknowledged that the program should be documented three times per week.	I 422	a. QMRP was re-trained clients' # 1 IPP exercise goal which includes an objective for client # 1 to exercise for 15 minutes at both AM/PM times by three consecutive months until 10/08. b. QMRP was retrained on client's #1 IPP goal to improve cognitive skills with the objective that client #1 will print her entire first name by for three consecutive months by 10/08. Additionally the QMRP was also in-serviced on job description of QMRP duties by the administration on 7/23/08 to include client program implementation of goals, BSP documentation by direct care staff and all other QMRP duties as assigned, which include consistence of oversight on all programs for all clients.	7/23/08